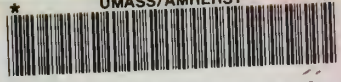


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TOWARD INDEPENDENT LIVING:
STATE SCHCOLS TO COMMUNITY PROGRAMS

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL RETARDATION

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A. INTRODUCTION

The following material was prepared by the Department of Mental Health/Division of Mental Retardation as a five year plan for the future use of the state schools for the mentally retarded and for the development of community services for currently institutionalized clients. This plan provides the link between the unique applications for certificate of need filed for each state school and the development of community ICF/MR's for which certificate of need applications will be filed for the next five years.

It should be noted that this plan is not intended to address the full range of services required by all mentally retarded persons within the Commonwealth, rather it is in response to the requirements of the determination of need process. The plan, therefore, primarily addresses the needs of the clients of the Department's large state institutions and the Department's commitment to provide those clients adequate and appropriate services.

The plan is divided into two sections. First, an overview of the state-wide picture including the following sub-sections:

- (1) introduction, which includes a historical perspective;
- (2) philosophy and goals of the Department of Mental Health/Division of Mental Retardation;
- (3) a discussion of the clients in the state schools and what services they need;
- (4) how the Department of Mental Health proposes to insure proper utilization of these services by its clients;

- (5) how the Department of Mental Health proposes to control the quality of these services, and
- (6) how the Department of Mental Health will work with the general public to allay their fears about this client group.

The second section is specific to the Commonwealth's plans for the development of intermediate care facilities for mentally retarded persons (ICF/MR) including a definition of ICF/MR, various administrative models, a discussion of costs and a region by region plan for the development of ICF/MR's. The projections for services to be delivered were prepared in conjunction with citizen boards on both the area and regional level.

Finally, it cannot be overemphasized that much of the following material is subject to the vicissitudes of the consent decree process as well as to executive and legislative review. In this sense some of the data is subject to change. Notwithstanding this, the population projected to be at the state schools and in community services in 1982 is a reasonable estimate.

Historical Overview

A brief historical perspective is necessary to put this document into a meaningful context.

The development of small community-based services is a national, as well as an international, movement, based on the concept of normalization in service delivery, which militates against large congregate facilities where handicapped clients

are segregated from the rest of society. There has been, and continues to be, a thrust to provide more normalized services for the clients living in this country's large state facilities.

In 1973, the first large sum of money was requested by the Department of Mental Health and authorized by the Legislature for the development of community residences in the state, operating on borrowed positions from the state schools. As of May 1, 1977, there were over 140 community residences (group homes) with more than 1200 beds under contract with the Department of Mental Health. In addition, there are 250 contracted placements in cooperative apartments and 156 contracted placements in specialized home care. All of these programs are operated by small private, non-profit organizations under contract to the Department of Mental Health.

Most of these organizations are local associations for Retarded Citizens. Through movement of clients from institutions to these community based services, the census at the state schools serving mentally retarded persons has declined from over 6,500 in the early 1970's to 5,349 current residents: 318 residents left the state schools during FY'77.

The availability of 75% reimbursement through the social services title (Title XX) of the Social Security Act for these programs greatly enhanced the Department's ability to expand the number and scope of these programs.

In an effort to further assist the states, Congress, in 1972, amended the Medicaid (Title XIX of the Social Security Act) legislation (PL 92-223) to include specific provision for

federal financial participation in Intermediate Care Facilities for the mentally retarded. In addition to adding this new service provision under Medicaid specifically for the mentally retarded, it also allowed for the first time public institutions for the mentally retarded to become eligible for federal reimbursement.

Following this amendment, federal Department of Health, Education and Welfare policies began to articulate the complementary goals of institutional reform and deinstitutionalization.

In Massachusetts, these two goals were articulated as well, and a strategy was developed which would utilize not only Title XX, but also Title XIX to improve the lives of mentally retarded persons.

State schools budgets in 1974 amounted to just over \$55 million. Through the availability of medicaid funding it was thought that the quality of institutional services could be improved and community services could be increased through the reimbursements earned under the Medicaid program.

In 1975, the first budget appropriation was made to bring the state schools into compliance with ICF/MR regulations. At the same time, community programs serving the mentally retarded continued to be a large component of the Title XX state plan (social services).

Most experts in the field of mental retardation feel that most clients currently served in large state institutions could be served more appropriately in smaller community based settings.

The rational planned development of these settings, however, must be accomplished over a period of years. For this reason it is crucial to improve conditions at the state schools as well as to develop services in the community. These goals are embodied in the Department's participation in the right-to-treatment suits involving the state schools, as well as the Department's participation in the ICF/MR program. Both reflect the Department's belief that people currently living in institutions have a right to decent care and habilitation.

1. The Consent Decrees:

Recognizing the impoverished conditions of the state schools, the Commonwealth has or intends to enter into consent decrees at Belchertown, Monson, Wrentham, Fernald, and Dever. Consent decrees have been completed, at present, at Belchertown and Monson. The thrust of these suits is that the present rights of clients must be protected.

The federal court and the Department have stated before that they do not consider expenditures for renovations of all buildings at the state schools to be a "waste of money..." even though many clients have left and are now being prepared to leave the state schools.

2. ICF/MR Regulations:

Compliance with the ICF/MR federal regulations obviously has an effect on the Department of Mental Health planning. It should be noted that timetables for compliance with the Title XIX requirements to some extent constrain the Commonwealth. New federal regulations will allow the states to develop a timetable

(through 1982) for phasing out certain sections of certified institutions. Such timetables must specify the units or buildings to be closed and describe where the clients will be placed in lieu of the full regulatory requirements to comply with the Life Safety Code. Over this five year period the state will still be permitted to claim reimbursement for client within buildings to be phased out.

Because it is not possible in five years to develop alternative placements for many residents of the six state schools who ultimately may need community services, the Commonwealth must renovate some buildings now for clients who may not live in those buildings in 10-15 years. Our full participation in the Medicaid ICF/MR program depends on this.

The differences between various types of residential settings discussed in this plan, particularly between community residences and intermediate care facilities for mentally retarded persons (ICF/MR), can best be described in terms of the following language within Massachusetts General Law Chapter 19.

In general, community residences provide care, supervision and training in the skills of activities of daily living such as cooking, self-care and transportation skills. ICF/MR's provide care and treatment that consists of not only training in activities of daily living skills, but also such things as physical therapy, occupational therapy, speech therapy, and nursing service as needed by the client. Thus ICF/MR can provide a wider array of services and thereby serve a more severely handicapped

population. The difference is in degree of service needed by the client.

Because of this wider array of services available through ICF/MR's, it is possible to move more severely handicapped clients out of the state institutions into more appropriate environments. The section which follows describes the ideological underpinnings of the activities of the Department of Mental Health for the next five years.

B. PHILOSOPHY AND GOALS REGARDING THE CARE
AND TREATMENT OF THE MENTALLY RETARDED

It is the belief of the Department of Mental Health that people should have access to the least restrictive and most normal living conditions consistent with their needs. Consequently, clients, as their needs dictate, should be prepared to move from (1) more to less structured living; (2) larger to small facilities; (3) larger to smaller living units; (4) group residences to individual living settings; (5) a segregated status to one integrated with community living and programming, and (6) dependent to independent living.

Basic Principles Upon Which Services to Mentally Retarded Persons are Developed.

1. A range of community services should be so complete that persons need not leave (and can be returned to) their home communities to receive those services necessary to meet their individual needs. To achieve this, activities of the Department must be developed to address concerns regarding a range of normalizing living conditions, adequate professional and special services, individualized development plans, external monitoring and planning accountability.

Earlier social policy viewed the large, residential institution as society's foremost solution to mental retardation. Current institutional models are based on society's changing perceptions of mentally retarded persons.

Up until the 1950's, the major residential service option in Massachusetts for mentally retarded persons was the large, custodial, segregated facility. Unfortunately, until recently those involved in the delivery of services to mentally retarded persons did not examine the effects of living in large, isolated and controlled congregate facilities upon the individuals who were housed there. Only recently have professionals and citizens recognized the detrimental effects that living in such facilities can have upon cognitive and adaptive behavior.

The development of a residential service system should be founded on the principle of normalization, the developmental model and a full recognition of the basic human and legal rights available to all citizens. This constitutes the goal for the residential service system: to insure movement of mentally retarded citizens to the most normal, least restrictive point on the living continuum.

Efforts of the Department of Mental Health to establish a range of ICF/MR facilities reflects those components necessary to insure that this normalization principle is met:

- (a) commitment to comprehensiveness of services;
- (b) commitment to provide those services necessary to allow persons to return to their own homes when possible;
- (c) development of a continuum of residential services for persons to progress to lesser amounts of structure and support needed as their developmental capabilities increase;
- (d) development of mechanisms to assure the availability of appropriate developmental services for each person;

- (e) development of a broad base of support services;
- (f) development of specialty services backing up general ones;
- (g) development of mechanisms to insure continuity of services.

2. The service system must insure the mobilization of activities, services and resources around each person's needs.

The plans of the Department and its seven regions for the development of systems of services involving ICF/MR's as flexible, movement oriented programs attempts to provide a posture toward the most appropriate, individually tailored services for each client by:

- (a) developing mandatory content and process for an appropriate Individual Service Plan for each client;
- (b) developing the availability of essential services to be applied to the Individual Service Plan for each client;
- (c) developing mechanisms which allow for contracting for services to meet individual needs;
- (d) strongly encouraging the utilization of generic and available specialized resources, and
- (e) providing for continuous internal and external monitoring of the ongoing appropriateness of the services for each person.

3. The local community services system should be highly visible and perceived as the major fixed point of responsibility for services to the mentally retarded in each community.

Quality control for the services rendered can only be established if major responsibilities are vested in one agency or office whose primary concern is for specific identified clients with effective regulatory powers vested in or delegated to authorities who can monitor contractual and generic services provided to the clients. These need to be on the local level (e.g. area and regional offices) separate and apart from institutional services to insure that adequate energy and attention is given to the development, operation and monitoring of community services.

Local visibility of the community service allows for: (a) more accountability to consumers and to the community, (b) a clear delegation and focus of community involvement with existing social and generic agencies, and (c) a clear perception in the minds of consumers and citizens of the viability of community services.

Maximal usage of the larger community for both residential and developmental programming sites is a critical element if the Department's objectives are to be satisfied. It is also the Department's belief that the total involvement of the larger community is an absolute necessity if future dilemmas of the type and magnitude we are now encountering at large state facilities are to be avoided and individualized services provided

for the mentally retarded citizens of the Commonwealth.

The following list enumerates the goals of the Department. These embody the principles cited above. The attainment of these goals is dependent on the availability of adequate resources.

- (1) To stimulate the development of protective and other social and socio-legal services for mentally retarded persons.
- (2) To provide access to generic service delivery systems for mentally retarded persons who are currently excluded as a result of unnecessarily restrictive policies and program orientation.
- (3) To insure the full and equal enjoyment of all human and civil rights by mentally retarded persons, who, because of the nature of their disability need assistance in exercising those rights.
- (4) To provide work and work-training programs for mentally retarded persons whose skills are currently inadequate to permit them to work independently in the labor market.
- (5) To develop programs and provisions designed for early intervention (ages 0-3) in order to prevent or ameliorate mental retardation.
- (6) To develop short and long-term domiciliary and special living arrangements for mentally retarded persons whose handicaps are currently too substantial to permit them to live totally independently.

- (7) To assist mentally retarded persons whose handicaps are of such severity as to preclude any substantial gainful activity, to obtain benefits and services to promote, achieve, or maintain their economic security.
- (8) To develop provisions for multi-agency systems, arrangements, and facilities which will provide comprehensive, coordinated, non-duplicative community services to persons with mental retardation.

These goals are consistent with those found in the Developmental Disabilities state plan.

In Section II, are the specific services to be developed by the Department of Mental Health over the next five years.

C. WHO ARE THE CLIENTS AND WHAT ARE THEIR NEEDS

In 1967 the Department of Mental Health, by law, was decentralized and divided into Regions and Areas. There are 7 regions and 40 areas. There are 6 large institutions serving the mentally retarded in the Commonwealth, one in each region except Region VI (Boston).

The following chart shows the January, 1977 population (average daily census) at each state school and the Hogan Regional Center by Region in which it is located:

TABLE 1
CURRENT STATE SCHOOL CENSUS

REGION	SCHOOL	JANUARY 1977
I	Belchertown	694
II	Monson	755
III	Fernald	1,272
IV	Hogan	278
V	Wrentham	1,203
VII	Dever	<u>1,147</u>
	TOTAL	5,349

Prior to 1967 clients were placed in any facility of the state where there was an opening. The result of this is that there are clients in each facility whose home region is other than the region where the facility is located.

As part of a comprehensive assessment performed on all the residents of these facilities in 1975, the home region of "meaningful tie" was determined for all clients. The definition of

meaningful tie is: (1) the location in which a client has friends or relatives or legal guardian that visit the client frequently, or (2) the initial city or town from which the client was referred.

The following chart shows the actual distribution by state school of clients by region of meaningful tie.

TABLE 2

DISTRIBUTION OF STATE SCHOOL POPULATION BY REGION OF MEANINGFUL TIE

		B	M	F	H	W	D	TOTALS
REGION I								
	Children	169	28	11	1	2	4	215
	Adults	377	109	16	0	2	0	504
								719
REGION II								
	Children	52	76	18	1	37	11	195
	Adults	62	283	169	0	45	34	593
								788
REGION III								
	Children	5	15	154	3	19	36	232
	Adults	10	44	350	2	38	54	498
								730
REGION IV								
	Children	6	10	47	259	20	35	377
	Adults	14	40	145	62	35	81	377
								754
REGION V								
	Children	5	11	43	0	132	49	240
	Adults	1	32	93	1	679	65	871
								1,111
REGION VI								
	Children	3	16	55	17	42	36	169
	Adults	1	46	98	3	61	61	270
								439
REGION VII								
	Children	1	7	15	1	25	202	251
	Adults	3	33	50	0	60	463	609
								860
<u>TOTALS</u>		709	750	1,264	350	1,197	1,131	5,401 ¹

¹ Reflects average daily census at the time of the survey (summer 1976)

Through the process of deinstitutionalization, the Department is attempting to return these clients to their home region of meaningful tie. The following chart shows mentally retarded clients served by the Department of Mental Health in other than state schools.

TABLE 3

MENTALLY RETARDED CLIENTS IN OTHER DMH SERVICES

John T. Berry Rehabilitation Center	130
Glavin Regional Center	50
Community Residences	1,039
Cooperative Apartments	234
State Hospitals	781
Early Intervention Services	<u>650</u>
TOTAL	2,884

In addition, the following mentally retarded clients are being served in various other locations. Many of these clients are inappropriately placed in their current settings and must also be planned for in the future development of community based services. Over the next five years, however, the primary emphasis of the Department of Mental Health, as mandated by Title XIX Compliance and consent decrees, will be on placing many of the current residents of the six state schools into appropriate community services, as well as providing services for a portion of the population currently living in the community without adequate programs.

TABLE 4

MENTALLY RETARDED CLIENTS CURRENTLY SERVED BY AGENCIES OTHER THAN DMH

	<u>Total</u>	<u># for DMH to plan for</u>
Pediatric Nursing Homes	255	<u>1</u> 166
Adult Nursing Homes	<u>2,329</u>	<u>2</u> 675
	2,584	841

3

A study prepared by Burton Blatt demonstrated that 1% of the general population is mentally retarded and in need of special services at some point in their lives. In Massachusetts the population is 5.8 million. This means that the possible incidence of mental retardation within the Commonwealth, today is 58,000 clients. Very few of these clients are actually served by the Department of Mental Health. Admissions to the state schools for the mentally retarded have been closed since 1970 for children under the age of six. In 1976, all admissions to the state schools were closed, except for admissions under emergency situations.

Through the implementation of Chapter 766 - Acts and Resolves of 1972 - Local Education Agencies are now mandated to provide or to arrange for services for all special needs children. This means that clients will, in general, not enter the Department

¹ According to DPH 166 out of 255 clients need community placement appropriate to the services provided by DMH.

² Approximately 675 of the mentally retarded persons in nursing homes are 55 or under and therefore are included in DMH 5-10 year plans.

³ A Plan for the Reformation of Services, Burton Blatt

of Mental Health network of services until age 22. Thus, in general, the Department of Mental Health provides services to mentally retarded clients between the ages of 0 and 3 and those over the age of 22. The largest exception to this are the 1,525 children between the ages of 3 and 22 who currently reside in the six state institutions. The Department of Mental Health will continue to provide or arrange for the residential services needed for this group of clients. As these clients move into appropriate community services, local public schools provide the educational service components for these children. (Currently each city/town has deducted from its "Cherry Sheet" assessment the average per pupil cost for each student in a state facility. Last year's average per pupil cost was \$1,200.)

In addition to this group there will be children whose comprehensive evaluations determine that they need residential placement outside the family. Some of these children will need ICF/MR services.

In 1975 all the residents at the six state facilities underwent a comprehensive assessment of their needs (an assessment which is updated annually). The following chart is a summary of the major residential settings found to be needed by the residents of the state schools.

TABLE 5

AGGREGATE SERVICE NEEDS OF STATE SCHOOL POPULATION

<u>Residential Setting</u>	<u># of Clients in Need</u>		<u>Total Number</u>
Residential Alternatives other than ICF/MR	Adults	536	1,299
	Children	763	
ICF/MR	Adults	3,282	4,044
	Children	762	

It is important to note that the regional plans for the development of residential services over the next five years are based on the aggregation of the service options chosen for each individual client as determined from the comprehensive assessment. These plans are based on the known needs of identified clients.

D. WHAT IS THE RANGE OF SERVICES?

Appendix 1 lists and defines services that should be available to mentally retarded persons. They fall into three broad categories: residential services, rehabilitative/habilitative services and ancillary and supportive services. One of the major goals of the Department of Mental Health is the development of a comprehensive system of services within each region of the Commonwealth. For a system to be comprehensive, three factors must be present. First, there must be an array of services so extensive that a client may secure all required services without leaving the region; and second, these services must interact in such a way as to form a cohesive unit so that the client experiences no break in continuity while receiving services or when moving from one program to another, and third, there must be continuity between day and residential programs and between one type of residential program and the next in the continuum of services.

Since 1975 when the first comprehensive assessment of needs of institutionalized clients was performed, the variety of services available to mentally retarded persons has increased and become more elaborate. The goal of this elaboration is to provide services which are individualized to the greatest degree possible. The Department of Mental Health is attempting to provide services which are based on each client's Individual Service Plan.

It must be understood that it is not the goal of the Department of Mental Health to provide by itself all the services a client needs. It is imperative that mentally retarded clients

utilize "generic" services to the greatest extent feasible. This means that a special service should not be developed for all service needs of mentally retarded persons which are the same as the needs of others in society. Mentally retarded clients should use neighborhood health centers, YMCA recreation programs, planned parenthood and other such examples of generic services as part of their normalization process. There is no reason to build costly duplicate systems for this population. It is the role of the Department of Mental Health to assist clients to utilize generic services so that these services become part of the comprehensive service system within a region.

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E. HOW DOES DMH PROPOSE TO ASSURE PROPER UTILIZATION OF SERVICE?

The Department of Mental Health, through its proposed regulations, is defining its responsibility for mentally retarded persons. These responsibilities contain two major components:

- (1) responsibility which insures that departmental clients get the right service to meet their needs; and
- (2) responsibility to insure program quality.

Under the proposed regulations, the Area Office would assure that the following services were provided: client intake, evaluation, periodic reevaluation and follow-along for departmental clients. This means that each Area Office of the Department of Mental Health would be a central point of responsibility for the intake of mentally retarded clients. An Area Office would receive an application for service and then determine initial eligibility as defined in the regulations. If a client were eligible for services, a comprehensive evaluation would be performed and the results of that assessment would be an Individual Service Plan which would detail the residential, habilitative/rehabilitative, and/or ancillary and support needs of that client. The Area Office would then, within fiscal constraints, provide these services, arrange for provision through its contracted programs, or assist the client to obtain service from the appropriate state agency or "generic" service.

The proposed regulations would require a periodic review of the progress of each client receiving Department of Mental Health services and assess whether or not placement is still appropriate.

Each Area Office would review annually the progress of clients receiving Department of Mental Health services in the area and determine whether appropriate services are being provided. Through this procedure - one which mandates the involvement of many participants including parents or guardian of the client - the Department will insure that clients are receiving services which are appropriate to their needs.

F. HOW DOES THE DEPARTMENT OF MENTAL HEALTH ASSURE THAT
QUALITY SERVICE IS BEING PROVIDED?

The Department of Mental Health is developing a method of insuring quality programs through licensing and evaluation.

Licensing

The Commonwealth (the Departments of both Public Health and Mental Health) is preparing to license for the first time residential and day programs for the mentally retarded. The licensing procedure will measure compliance with building and health codes as well as the programmatic requirements within the appropriate Department's regulations. Department of Mental Health regulations provide minimum compliance levels for the physical facility, the environment, and staffing. Providers of services will be permitted to prepare a plan of correction with timetable for compliance for any deficiencies noted. A license will be valid for a period of 2 years, but every licensed facility will also be subject to an annual review.

The Evaluation Process

The evaluation process being developed by the Department will have the capacity to provide in-depth assessments of both programmatic and administrative criteria of quality guided by the principle of Normalization.

The purpose of the evaluation system will be:

- to provide the Department of Mental Health staff and vendors with information they need to improve programs
- to pinpoint technical assistance and training needs

- to aid priority setting for short term and long term planning
- to facilitate communication among the levels of the Department of Mental Health (vendor, area, region, central office)
- to facilitate lateral communication among vendors
- to formalize regular program review and feedback activity
- to encourage the vendors to continually focus on methods to improve their services

Both the process and results of evaluation are envisioned as useful to improving program quality. By participating in self-surveys, program staff, area and regional staff, consumers and citizen board members can focus on features which may be overlooked in their struggle to direct day to day operations at each level of the service delivery system.

Preparation of the Community

The success of the development of community services will require a significant amount of planning, preparation and training not only for those returning to the community, but also for the community as a whole. To insure that this transition is successful, the Department has, as one of its primary objectives in this planning effort, engagement in a campaign which will educate and inform the public about mentally retarded individuals and the needs and capabilities of such persons. The parameters of this endeavor will include: (1) the development and implementation of a mass media campaign to include television, radio and newspaper

coverage about mentally retarded persons and programs and services available to them; (2) the development and implementation of a community-based training and leadership program aimed at educating community leaders as spokespersons and resource persons for the mentally retarded; and (3) the development and publication of brochures and topical information about mental retardation for public distribution.

During the past years, the Department has worked closely with its Mental Health and Mental Retardation Advisory Boards, Regional Councils and consumer and advocacy organizations. These groups have played a substantive role in the planning for Title XIX implementation and development, both at the state institutions and for community-based ICF/MR's. The Department will continue to work closely to build upon this already existing partnership to ensure the implementation of Title XIX ICF/MR planning.

The second section of this plan deals specifically with the development of community Intermediate Care Facilities for mentally retarded citizens. The future of many currently institutionalized clients rests on the successful implementation of this plan.

SECTION II

A. DEFINITION OF AN ICF/MR

As described in Section I, an ICF/MR provides both care and treatment. This includes not only the development of the activities of daily living skills, but also a variety of treatment services which must be available to each client as needed. According to the federal definition, an ICF/MR is a facility which "provides room and board, a planned program of care and supervision on a continuous 24-hour a day basis and active treatment". Active treatment means "regular participation in accordance with an individual plan of care in professionally developed and supervised activities, experiences or therapies".

The individual client is the basic element around which the federal ICF/MR regulations were written. The federal regulations require a comprehensive pre-admission evaluation with monthly updates and, at least, an annual review. In addition, the regulations describe the mandatory services which must be available as needed. These are physical therapy, occupational therapy, speech therapy, social work, psychology, medical, dental, nursing, recreation, pharmacy, dietary, resident living, training and habilitation services.

Two essential elements of the regulations, however, are different from those governing other long-term care facilities. The first is that all services are to be provided as needed by the client. This reflects an emphasis on both the evaluation process and on the Individual Service Plan which defines the objectives for each client. Because of the array of mandatory

service options as well as the emphasis on individual needs, each ICF/MR will be slightly different, depending on the services needed by the clients living there.

Secondly, the regulations provide that almost all of the service can be provided through contract or other formal arrangement. This provision is consistent with the underlying philosophy that it is essential to integrate MR clients into the community to the fullest extent possible. Using contract services means that the clients can go out of the residential units to receive many services (including generic services such as dental, medical, recreational, etc.), rather than have all the services come to the residence. For this reason, the most common configuration of an ICF/MR will include at least two sites where services will be provided: the residential program site; and, the day (or training and habilitation) program site.

The federal regulations further define two types of buildings in which an ICF/MR program shall occur, again, based on the needs of the clients to be served. For clients who are ambulatory and capable of self-preservation, the buildings may meet the lodging or rooming house section of the Life Safety Code, with the further stipulation that there be less than 15 clients housed in one building.

For larger groupings of clients (more than 15) or for clients who are nonambulatory or mobile nonambulatory and not capable of self-preservation, the ICF/MR facility must meet the institutional section of the Life Safety Code. The federal ICF/MR Regulations require that ICF/MR's be licensed according to state law. Therefore, state licensing regulations are being established. These regulations are based on federal regulations but are somewhat more specific with regard to state requirements and responsibility for the client.

Department of Health, Education and Welfare, in proposed regulations considered changing the requirements on "capable of self-preservation" such that clients who are mobile-nonambulatory and/or not capable of self preservation (see Appendix 2 for definitions) but for whom an acceptable evacuation plan could be developed could be housed in ICF/MR's which meet the lodging house code rather than the institutional code. Although the final regulations did not contain this provision, the Commonwealth, as well as several other states, are requesting a special waiver to utilize the lodging house code under the proposed regulation.

Because of the differing client eligibility requirements for the two types of building codes required in the ICF/MR regulations, it becomes necessary to differentiate between the number of facilities that will be used for those who are ambulatory and capable of self-preservation, and for those who are nonambulatory and/or not capable of self-preservation.

Approximately 20% of the clients currently living in state schools are nonambulatory.¹ Therefore, assuming that the waiver is granted the vast majority of ICF/MR's, or approximately 80% of the clients, will meet the less restrictive lodging or rooming house section of the Life Safety Code because the clients are ambulatory and are potentially capable of acquiring self-preservation skills.

¹Perceived Dependence - Independence, Derivations and Implications of an Empirically Based Factor in Planning for Residents in Public Institutions for the Mentally Retarded in Massachusetts, Doris Fraser, 1971.

B. ICF/MR COSTS

Currently only the state schools are certified in the Commonwealth as ICF/MR's. In 1974, before the state was eligible for federal reimbursement, the aggregate budget for the state schools was approximately \$55 million; 100% state dollars. The aggregate operating budget for the state schools is now approximately \$75 million. Currently the Commonwealth earns approximately \$26 million in Medicaid reimbursements annually. The per diem rates at each facility are as follows: Belchertown \$54.49, Monson \$48.21, Fernald \$48.37, Hogan \$71.73, Wrentham \$37.52, Dever \$38.20.

Anticipated capital expenditure of \$45 million at the state schools over the next five years in conjunction with an increase in staff and a decline in census through the development of community services will result in a higher staff/resident ratio over the same time period and will increase the per diem rate to a range of \$75 - \$150.

When the Commonwealth elected to provide ICF/MR services under the Medicaid program in the public institutions, it also elected (by mandatory federal provisions) to provide ICF/MR services in the community.

Extensive research has been done to estimate costs for the ICF/MR program. Model working drawings were prepared for both an 8 and a 12 bed ICF/MR. The construction of these facilities was costed out, meeting both the institutional and the lodging house Life Safety Codes. In addition, costs were determined for the purchase and renovation of already existing facilities which would meet codes. Staffing and support services were costed as well, with the technical assistance of the Rate Setting Commission. The per diem rate for an ICF/MR for persons who are ambulatory and capable of

self preservation is approximately \$50 per day, with additional day program costs of approximately \$12.50 per day.

C. NUMBER OF CLIENTS IN NEED OF ICF/MR SERVICES

Burton Blatt's study referred to earlier (part C, Section I) states that the incidence of mental retardation is 1% of the general population, or 58,000 mentally retarded people in the Commonwealth of Massachusetts. In addition, the study states that approximately .1% of the general population is substantially handicapped and in need of residential services such as ICF/MR's. According to this study there are 5,800 potential clients in Massachusetts at any one time who are in need of ICF/MR services.

Many of the clients in need of ICF/MR services are already being served by the Department of Mental Health or by other agencies. However, many of these clients are either being served inappropriately or are in facilities which are not normalizing for the clients. The following chart demonstrates the identified known need for ICF/MR services.

TABLE 6

NUMBER OF CLIENTS IN NEED OF ICF/MR SERVICES

<u>Current Location</u>	<u>No. of Clients in Need of ICF/MR Services</u>
State Schools	4,044
State Hospitals	551
Adult Nursing Home	675*
Pediatric Nursing Home	<u>166*</u>
TOTAL	5,436

* This number does not reflect the total number of MR clients in each of these settings but rather the number of individuals who can reasonably be expected to need ICF/MR services in the next 5 to 10 years. There are actually 2,329 MR clients in adult nursing homes and 255 in pediatric nursing homes.

In addition, besides these known clients, there is another group of clients currently living at home who will also need ICF/MR services. Many of these people are currently under 22 and attending special education programs in their home communities, but are at risk in the future of needing ICF/MR services. Others, at more immediate risk of needing ICF/MR services, are adults currently living at home with their aging parents.

D. CONSIDERATIONS OF THE NUMBER OF BEDS NEEDED OVER THE LONG TERM

The number of beds required over the long-term for ICF/MR need not equal the known number of clients in need of ICF/MR services because the primary goal of all residential services to mentally retarded clients is to move the client to the least restrictive residential alternative compatible with his or her needs. For many of the clients who are currently assessed as in need of ICF/MR services, this will mean movement through ICF/MR services into community residences, cooperative apartments, specialized home care and perhaps, even independent living.

Long term (5 year) studies have been performed in two states to determine the rates of movement from large institutions through community services into less restrictive settings or independent living. In Nebraska, at the Eastern Nebraska Community Office of Retardation, when clients were deinstitutionalized from Beatrice State Home (the Nebraska institution), their mean length of stay was 27 months in all residential training programs prior to moving to less restrictive living settings. It must be clear that not all clients were ready to move in 27 months. Rather some clients were ready to move after 6 months while others were not ready to move into less restrictive services for 4 years.

In Pennsylvania, approximately 150 clients per year over a 4 year period (or 600 clients) have moved from large state institutions, through a service similar to ICF/MR, into less restrictive community settings.

Therefore, while the number of clients currently in need of ICF/MR services approaches 5,800 there is no reason to plan for 5,800 beds.

There are a number of variables which impact on the long-term need of the actual number of ICF/MR beds needed. These variables are: (1) changing trends in types of services offered to children; (2) the provision of alternative services for persons over 65 replacing the active treatment required in the ICF/MR, and (3) the historical lack of services which inflates the current number of known clients in need of ICF/MR services at the state schools.

1. Of the potential 5,800 clients reported in the Blatt study who are in need of ICF/MR services at any one time, approximately 38% or 2,204 are children (applying the percentage of children in the general population to the mentally retarded population). This issue is specifically raised because the growing trend in provision of services to all disabled or infirm people, whether they are mentally retarded, mentally ill or simply infirm by virtue of age, is to provide services to clients in their own homes.

With respect to mentally retarded children, a goal is to change assumptions about the family's innate inability to cope with the "condition" called "mental retardation" or the resultant need to construct an extensive array of settings outside of the home. The following are the assumptions which replace the above:

- a. The family is capable of providing the most appropriate residential environment for their child in most cases.
- b. The service provider should assume that its responsibility in most cases is to supplement the normative environment, not to replace it.
- c. Mentally retarded children have a human right to live in a community within a family structure whenever possible.

Evidence of these new assumptions in Massachusetts are:

1. The increase in early childhood intervention services for children ages 0-3 and their families; and (2) implementation of Chapter 766 which mandates that the school systems provide services to all children. The current provision of early intervention and support services to families in crisis is at best scarce. However, as these services develop they should reduce the need for residential beds for children outside the home.
2. The ICF/MR regulations mandate that for each client in an ICF/MR there must be active treatment. Elderly mentally retarded clients should have the same right to retire as others in society. This does not mean that services to people over 65 should stop, but rather that the active treatment should be reduced, more appropriate services should be delivered, i.e. home health care, rest homes or other services approved for a geriatric population.

E. ICF/MR: MODELS AND LINKAGES WITH OTHER SERVICES

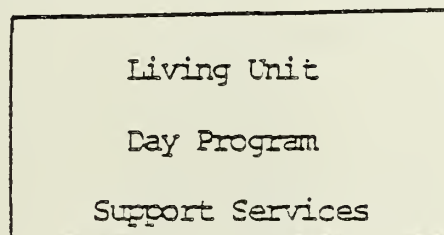
The federal ICF/MR regulations mandate a comprehensive array of services available to each client. They also mandate that service be delivered based on an individual service plan. As the client progresses and meets behaviorally stated objectives, the service plan should be adjusted. The following models for ICF/MR service delivery allow the greatest flexibility not only in amending the service plan but also in changing the level of care provided to the clients (easier movement to less restrictive residential settings).

- The following models are alternative ways of portraying an ICF/MR. Each model of an ICF/MR shows how the full array of services needed for mentally retarded persons can be provided by a public agency (Department

of Mental Health) in conjunction with private agencies, including generic service agencies. The locus of responsibility (public vs. private) for delivery of the various services mandated under the regulations changes in the various models. Model number 3 provides the greatest degree of community integration for the client, with the greatest use of generic resources. For this reason it is also the most cost-beneficial. It uses services already available in the community, thereby obviating the need to build costly duplicative systems for a specialized group of clients.

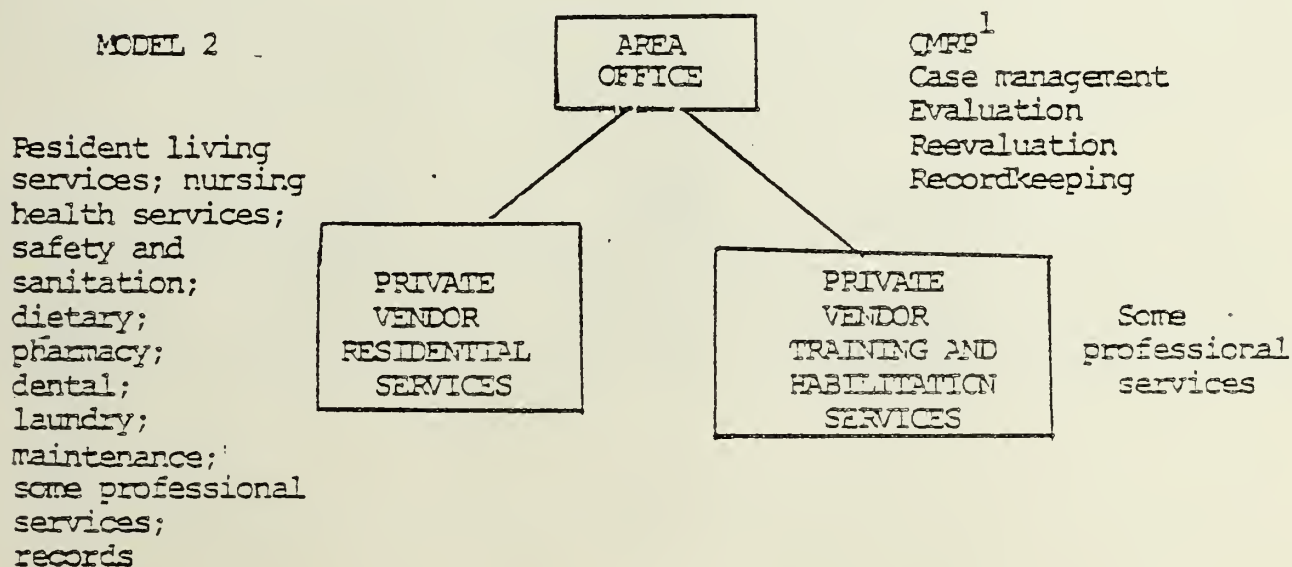
The first model is the typical "nursing home" model where all activities center around the residential unit. This provides the least integration for the client. All services are provided within the confines of the ICF/MR.

MODEL 1



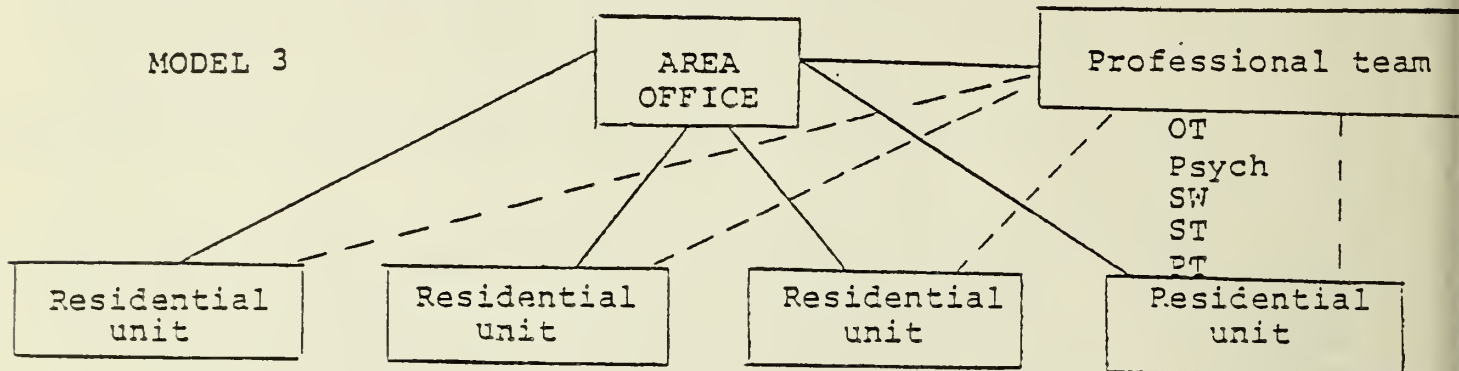
The following models show the client receiving more and more services from generic agencies and vendors and are more desirable.

MODEL 2

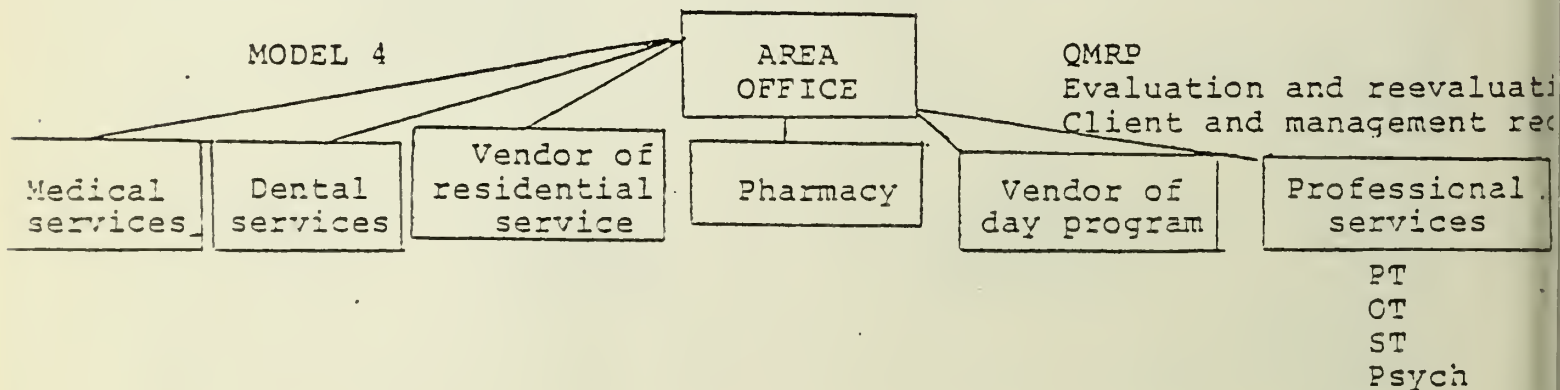


¹QMRP means Qualified Mental Retardation Professional. According to the regulations for ICF/MR the QMRP must direct the ICF/MR and a QMRP must be responsible for client management.

In model 2 some of the services are on the staff of the vendor while others are under contract or agreement between the vendor of private residential services and the provider of other services, e.g. pharmacist, dentist, visiting nurse.



In model 3 the area office has on its staff, or on contract, an array of the mandatory professionals required under the ICF/MR regulations. (see appendix 3) The professional staff on that team would be available to provide services to all clients of residential units within the area. This model of an Health Maintenance Organization for professional therapeutic services rather than purely medical, would be a far more cost-effective method for providing services rather than each individual program utilizing individual professionals and paying them on a fee-for-service basis.



In model 4 the Area Office not only monitors the residential and day services, but also arranges for all other ancillary and support services. Thus, under either contract or agreement, the area office arranges for all primary and ancillary services for all ICF/MR residents in the area. The charts in Appendix 4 further illustrate this point. Across the top of the page are the mandatory services for ICF/MR. Across the side are the various points at which service delivery can occur, both in the public and private sector. The checkmarks on the chart show the locus of responsibility for provision of each mandatory services. Although in each model all mandatory services are provided, models 3 and 4 enable the client to be more easily integrated into community life.

F. FIVE YEAR PROJECTION FOR SERVICES TO BE DEVELOPED

Table 7 presents for each fiscal year the number of placements to be developed within each region by service category. FY'77 reflects contracts for service which are currently allowing clients to be placed into community programs. FY'78 reflects funds which are requested in the FY'78 budget. FY'79 through FY'82 are projections prepared by the regions in conjunction with the area boards and regional councils and agreed to by Central Office for the 5 year period.

Table 5 shows that there are 4,044 residents in the state schools in need of ICF/MR services. The mean length of stay of these clients at the state schools is approximately 20 years. It is only within the last five years that large inputs of staff have been added to upgrade services within the institution. Prior to that time the institutions had to operate at substantially understaffed levels. This resulted in a "backlog" of clients in state schools who essentially have become additionally handicapped by virtue of living in the state schools. It is anticipated that many of these clients will progress rapidly to less restrictive settings than ICF/MR's when they are able to receive more individualized services in more normative settings.

Consequently, the total number of clients currently in need of ICF/MR is skewed upward because of the inclusion of these long-term institutionalized clients in this figure. Thus, the number of beds needed over the long-term (10-15 years) should not match the number of current clients because many of the clients should move through ICF/MR into less restrictive settings.

TABLE 7

6 YEAR PROJECTION (INCLUDING FY'77) OF NUMBER OF PLACEMENTS TO BE DEVELOPED BY REGION

SERVICES	REGIONS	I	II	III	IV	V	VI	VII	TOTAL
77									
Community Residence		11	54	14	28	59	47	49	262
Operative Apartment		9	0	15	0	0	4	17	45
Specialized Home Care		50	20	13	25	6	10	42	166
/MR		0	0	0	0	0	0	0	0
TOTAL									<u>473</u>
78									
Community Residence		32	52	46	38	42	44	53	307
Operative Apartment		40	10	22	22	0	28	0	122
Specialized Home Care		30	12	7	30	20	40	10	149
/MR-work begun but placements		0	0	0	0	0	0	0	<u>0</u>
TOTAL									578
79									
Community Residence		0	0	0	0	0	0	0	0
Operative Apartment		20	10	0	5	5	5	10	55
Specialized Home Care		25	15	15	14	12	17	12	110
/MR		40	24	16	24	16	8	32	<u>160</u>
TOTAL									325
80									
Community Residence		0	0	0	0	0	0	0	0
Operative Apartment		30	10	5	12	5	7	12	81
Specialized Home Care		25	15	10	14	15	17	17	103
/MR		24	32	24	24	32	24	16	<u>176</u>
TOTAL									360
81									
Community Residence		0	0	0	0	0	0	0	0
Operative Apartment		35	10	5	15	5	8	12	90
Specialized Home Care		25	15	10	14	15	18	8	105
/MR		20	24	24	20	36	20	24	<u>168</u>
TOTAL									363
82									
Community Residence		0	0	0	0	0	0	0	0
Operative Apartment		27	10	3	3	5	5	25	78
Specialized Home Care		25	15	10	15	15	18	15	113
/MR		24	20	30	30	35	24	22	<u>185</u>
TOTAL									376

Grand Total of Placements 2,475

Table 7 shows the development of 2,475 community placements by the end of FY'82. Of these placements, approximately 655 will be under the age of 22.

Many issues were considered in developing these projections. The services to be developed match recommendations for placement from the state school clients' individual service plans. It is difficult to project over a 5 year period the precise distribution of clients among categories of community services (community residence, cooperative apartment, specialized home care). However, for purposes of this document, projections were made based on current individual service plans. These, of course, are subject to change as the clients develop.

Intermediate Care Facilities are not shown as currently ready to accept clients until FY'79. Several vendors, however, are ready to develop ICF/MR's in the community. Because of the complicated process of becoming certified as an ICF/MR most vendors will not be ready to accept clients until FY'79. This complicated process includes 1. obtaining a determination of need, 2. licensure, 3. purchase and renovation or new construction of an ICF/MR to meet appropriate building codes, 4. certification of program and building, 5. obtaining from the Rate Setting Commission a rate, and 6. obtaining a provider certificate.

Another issue that was considered in preparing these projections was the return of clients to their region of meaningful tie. Region VI (which does not have a state institution) and Region IV which

has had an Institution for only the last seven years) for many years sent their clients to out-of-region facilities, particularly Fernald, Wrentham and Dever State Schools. Thus, many of the clients leaving these three institutions will be returning to Region IV and VI.

Finally, among the issues considered in preparing these projections was client movement to less restrictive residential settings. For example, it is not expected that clients will move directly from a state school into a cooperative apartment and semi-independent residential services. Clients will move from community residences or specialized home care or ICF/MR's into a cooperative apartment. The space then left in the community residence or ICF/MR will be filled by another client needing that particular service.

Table 8 summarizes the placements to be developed by service category by fiscal year, while Table 9 summarizes the number of facilities to be developed.

TABLE 8

SUMMARY OF PLACEMENTS TO BE DEVELOPED BY FISCAL YEAR

	Community Residence	Cooperative Apartment	Specialized Home Care	ICF/MR	Total
FY'77	262	45	166	0	473
78	307	122	149	0	578
-79	0	55	110	160	325
80	0	81	103	176	360
81	0	90	105	168	363
82	0	78	113	185	376
	<hr/> 569	<hr/> 471	<hr/> 746	<hr/> 689	<hr/> 2,475

TABLE 9

NUMBER OF FACILITIES TO BE DEVELOPED BY FISCAL YEAR

	<u>Community₁ Residence</u>	<u>Cooperative₂ Apartment</u>	<u>ICF/MR¹</u>
FY'77	33	9	0
78	38	30	0
79	0	14	20
80	0	21	22
81	0	23	21
82	0	20	24
	<hr/>	<hr/>	<hr/>
TOTAL	71	115	87

During the next five years, the Department of Mental Health plan to develop 87 ICF/MR's for 689 clients. Although no clients are projected to enter ICF/MR's during FY'77 and FY'78, it is anticipated that vendors will be applying for Determination of Need and preparing their programs during that time period so that clients may enter ICF/MR's in FY'79.

¹ Each facility at average of 8 people.

² Each cooperative apartment at average of 4 people.

G. IMPLICATIONS FOR STATE SCHOOLS

The following chart reflects the average daily census or the in-residence population of January 1977 for the 6 affected state schools.

TABLE 10

STATE SCHOOL POPULATION

Belchertown	694
Monson	755
Fernald	1,272
Hogan	278
Wrentham	1,203
Dever	<u>1,147</u>
TOTAL	5,349

The following table reflects the current in-residence population and the projected population for each school at the completion of the renovation period (as reflected in the Unique Applications for DCN for each school), and finally, the number of people who will be placed into community services in accordance with their individual needs.

TABLE 11

REDUCTION OF CENSUS BY STATE SCHOOL

	<u>Census Jan. 77</u>	<u>1982 Census at Completion of Renovation</u>	<u>Number to be placed</u>
Belchertown	694	278	416
Monson	755	500	255
Fernald	1,272	925	347
Hogan	278	240	38
Wrentham	1,203	725	478
Dever	1,147	675	472
	<u>5,349</u>	<u>3,343</u>	<u>2,006</u>

In order to determine the numbers of residents to be placed in community service by 1982, each state school client underwent a comprehensive evaluation to determine their service needs. Concomitantly the department contracted for a detailed study which analyzed the capital improvements necessary to bring part or all of the state schools up to the standards for ICF/MR. In this study, Campus Futures: In the Balance, Environmental Design Group, (EDG) evaluated the buildings according to a range of variables including the ease of making the environment more humane, meeting the per person square footage requirements in the federal regulations, and the cost of renovating each of the buildings according to two quality levels of renovations. The EDG report presented several capital improvement options for each state school. Each option reflected a different assumption of the number of clients to be placed from the institution into the community.

The options were presented in the form of a "decision-tree," in which, after each phase of construction (the renovation of a certain number of buildings), the Department had the option to choose to renovate buildings that would house a higher or lower number of clients or to continue along the same course.

The department then essentially chose one option for each state school. The chosen option appears at present the most reasonable, given the different kinds of constraints and advantages in each region (zoning problems or the lack thereof, ease or difficulty of finding suitable facilities, capacity of vendors or area staff). However, it cannot be overemphasized that this option is dependent on and subject to revision as a result of the Consent Decree process.

The option for each state school reflects the need for community services for 2,006 clients. Over the course of the 5 year period, should any of the underlying assumptions be revised or changed, another option could be chosen for each state school and, thus, a different number of community placements developed.

TABLE 12

PLACEMENTS FROM INSTITUTIONS BY FISCAL YEAR

	<u>Total Placements</u>	<u>Placements to be made from state schools</u>
FY'77	473	293
78	578	462
79	325	244
80	360	288
81	363	290
82	376	300
	<u>2,475</u>	<u>1,877</u>

Table 12 shows that a total 2,475 placements would be made during the period FY'77 through FY'82. Of these placements, 1,877 would be clients placed from the state schools. In addition, to these placements there are 129 vacancies in existing community programs to be filled by state school residents. Thus, the total number of placements that can be made by filling current vacancies, and those placements projected over the 5 year period is 2,006.

Referring back to Table 11, the renovation option chosen by the Department assumed that approximately 2,000 people needing community services would be afforded them. Thus, the projected community placements meet the reduced census projected at each institution.

H. COSTS AND REIMBURSEMENTS OF PLANNED ICF/MR SERVICES

Table 8 presented the number of ICF/MR's to be developed over the 5 year period. That is 689 placements in 87 ICF/MR's at an average of 8 persons per facility. Table 13 shows the number of ICF placements (A and B)* to be developed each fiscal year, FY'79-82 and the cost and Title XIX reimbursements associated with those placements. Each fiscal year represents new cost and cumulative costs.

*ICF/MR B (residential portion) - rate is \$50/day

ICF/MR A (residential portion) - rate is \$70/day

Day Program - rate is \$12.50/day

A \$2,000/client cost was added to residential portion for professional services, not included in the daily rate.

TABLE 13

PROJECTED COSTS AND REIMBURSEMENTS FOR ICF/MR.'s BY FISCAL YEAR

	<u>Numbers of Clients</u>	<u>Cost</u>	<u>Reimburseme</u>
FY79			
ICF/MR "A"	26	\$ 716,300	
ICF/MR "B"	134	2,713,500	
Day Programs	120	375,000	
Total		\$3,804,800	\$1,902,400
FY80			
ICF/MR "A"	36	\$ 991,800	
ICF/MR "B"	140	2,835,000	
Day Programs	140	437,500	
Total		\$4,264,300	\$2,132,150
FY81			
ICF/MR "A"	36	\$ 991,800	
ICF/MR "B"	132	2,673,000	
Day Programs	134	418,750	
Total		\$3,783,550	\$1,891,775
FY82			
ICF/MR "A"	36	\$ 919,800	
ICF/MR "B"	149	3,019,250	
Day Programs	149	465,625	
Total		\$4,404,675	\$2,202,337
<u>Cumulative Grand Total</u>	689	\$16,257,325	\$8,128,662

Conclusion

An analysis was prepared of the relative costs and benefits of implementing the program proposed in this plan, including the projected total costs of the state schools as well as community services.

Several combinations of factors were analyzed. The variables within these combinations included the extent of reallocation of cost savings from the state schools due to reduction in population and the degree to which the proposed community programs were implemented.

Table 14 presents the costs of the option which has been chosen by the department.

Table 14

Total 1982 Costs and Reimbursements for State
Schools and Community Services¹

	<u>Costs</u>	<u>Reimbursements</u>
State Schools ²	\$101,052,788	\$38,454,539
Community Services	\$53,694,480	\$7,316,352
Total	\$154,747,268	\$45,770,891

¹ Total institutional costs include operational budgets of each school, indirect costs as well as capital costs. Appendix 5 provides the breakdown of these costs.

² The above figures do not include the addition of 346 new staff to be added to Wrentham, Dever and Fernald during FY'78. In addition the figures do not include any additional staff which will be necessary for compliance with S 249.13 of the ICF/MR regulations determined as a result of a joint DME-DPH study currently underway. These positions and related costs will be incorporated after the Sec. 13 staffing is determined. Appendix 6 shows the formulas used to determine the reallocation. The funds saved at the institutions are shown as lowering the net state costs.

This plan proposes the full implementation of the community services as described earlier including the development of community ICF/MR's as well as the reallocation of state school resources into the community. The Net State Cost represented in this five year plan is approximately \$109 million for both institutional and community services.

For programmatic and humane reasons it is essential to move ahead with the development of community services as described in this plan. While the task before the Commonwealth is tremendous, with all agencies working together the plan is feasible and cost effective.

As described earlier, the evidence that small community based services facilitate the growth of the clients is overwhelming. It is also essential not to neglect those clients who remain in the large facilities for a longer period of time. The course recommended by this plan allows for both the development of community services and the improvement of the state schools. It is also the Department's intention to reallocate to the community cost savings realized at the state schools when the population is significantly reduced so that the Department will not provide duplicative services.

It must be understood that this plan provides only a framework for the activities proposed for the next five years. Reassessment will be a continuous process and changes will obviously occur.

A total reassessment will be made after the second or third year of implementation have been accomplished to determine whether the assumptions are still valid and to begin to look at the next five years.

As stated earlier, this plan does not impact on the total universe of need within the Commonwealth, it does not address the needs of most clients who never entered institutions. Nonetheless, it is an important step in the Commonwealth's effort to provide necessary and appropriate services for mentally retarded persons.

APPENDIX I

STANDARD DEFINITIONS FOR
MENTAL RETARDATION SERVICES

I. Residential Services

A. Apartment living

1. Independent living
2. Minimal supervision
3. Apartment living/training

B. Specialized home care

1. Emergency/respice
2. Temporary
3. Infant & Toddler development
4. Child and adolescent development
5. Adult skills development

C. Group homes

1. Temporary
2. Children's 5-day residences
3. Child & adolescent development
4. Adult skills development
5. Residence for the elderly
6. Residence for severely medically or physically handicapped persons
7. Intensive behavior shaping
8. Structured correctional residence

D. Institutional services

1. State school/community preparation
2. State school/skills development
3. State school/intensive behavior shaping
4. State school/intensive medical services
5. State hospital/MR unit
6. State hospital/unit for emotionally disturbed mentally retarded individuals
7. Nursing home

II. Rehabilitative/Habilitative Services

A. Vocational

1. On the job training/apprenticeship
2. Integrated industrial work station
3. Non-integrated industrial work station
4. Community sheltered workshop/industrial support
5. Institutional sheltered workshop
6. Community sheltered workshop/production and marketing

7. Institutional sheltered workshop/production and marketing
8. Sheltered workshop/prevocational training
9. Institutional sheltered workshop/prevocational training
10. Day activity/industrial support
11. Institutional day activity/industrial support
12. Day activity/production and marketing
13. Institutional day activity/production and marketing
14. Day activity/prevocational training
15. Institutional day activity/prevocational training
16. Employment training
17. Employment placement

B. Developmental Programs

1. Early intervention/in-home
2. Early intervention/out-of-home
3. After school programs
4. Adult education

III. Ancillary and Supportive

A. Case Management

1. Case-finding/outreach
2. Intake
3. Family casework
4. Guidance and counselling
5. Support and consultation to public schools

B. Therapeutic and Medical Services

1. General health services
2. Special medical services
3. Screening and diagnosis
4. Speech and hearing therapies
5. Mental health services
6. Preventive health services
7. Mobility training
8. Provision of prosthetic devices
9. Visiting nurse services

C. Supportive Services and Administration

1. Information and referral
2. Parent training
3. Sex education
4. Recreation
5. Transportation

6. Public education
7. Staff training and development
8. Court liaison
9. Administrative services
10. Volunteer services
11. Individual Service Plan Development

I. Residential Services

Residential services include the provision of training, guidance and support to mentally retarded persons in their place of residence. Although residential services generally means the provision of living arrangements outside the natural home, activities carried out in surrogate environments such as those listed below may likewise be conducted in the client's own home.

The types of residential services listed below are not specific to severity of handicap. Certain highly specialized programs, such as intensive behavior shaping or residences for persons with severe medical disabilities, are designed for person who have physical or behavioral disorders in addition to their primary diagnosis of mental retardation. The degree to which they are mentally retarded is not a determinant of their suitability for residence in those facilities. Any mentally retarded person, from profoundly to mildly retarded, may be considered suitable for placement in the programs listed below. The intensity of programming should vary as a function of the degree of disability, but that programming may be carried out in any location where staff have the necessary skills.

A. Apartment Living

1. Independent living. Residential service provided to an adult client through regular visitations and assistance at his independent living situation, but with no live-in staff. This should be differentiated from follow up or case management services by the planned, regular support given by residential service personnel rather than social service.
2. Minimal supervision. Staffed semi-independent living situation - provides only partial staff support in the residence, apartment, etc. to assist in the refinement of independent living skills. Staff generally live off-site, but may live-in on a co-resident peer capacity.
3. Apartment living/training. Live-in staff in an apartment provide structured training in housekeeping and home management skills to prepare the client for independent living.

B. Specialized home care

1. Emergency/respite. The placement of one to three mentally retarded individuals in a home on a short-term basis, to relieve a crisis in the person's family or allow the family to engage in necessary activities

in which the mentally retarded family member cannot participate. This service is similar to that provided by respite care facilities, except that the placement does not include large group living.

2. Temporary. Placement of one to three individuals in a home on a short-term basis while other living arrangements are prepared. Individuals temporarily placed will not return to their natural homes in the immediate future, nor will they remain in that specialized home care site. They will be permanently placed in another location.
3. Infant and toddler development. The placement of one to three mentally retarded infants (age 0-3) in a family home. Services provided include nurturance and basic child development in a family environment (either with a surrogate family or with the natural family with additional specialized support).
4. Child and adolescent development. Placement of one to three children and/or adolescents with a family. Services include child development, supervision, behavior modification, and recreation designed to promote the children's growth. Adolescents may be placed with young adult peers.
5. Adult skills development. Placement of one to three adults in a private home. Services provided include support in learning activities of daily living, home management skills, utilization of community resources, and supervision.

C. Group homes

1. Temporary. A residence for six to eight for whom the usual residential setting is shown to be temporarily unavailable, inappropriate or otherwise not consistent with the best interests of the individual. Respite and emergency care may be provided in these facilities.
2. Children's 5-day residence. A group residence that operates only 5 days a week either (a) attempting to maintain a child's ties with his family on weekends, or (b) provided only during the week so that the child can attend a special day program which may be at too great a distance from his home to commute daily.
3. Child and adolescent development. A residence for 6-8 children and/or adolescents. Residents learn basic skills in a family atmosphere.

4. Adult skills development. A residence for six to eight adults who are in competitive or sheltered employment. Residents learn skills of daily living and learn how to use community resources in preparation for their moving into less structured environments.
5. Residence for the elderly. A residence for six to eight adults past the age where they are able to work. Services include assistance in carrying out activities of daily living, utilization of community resources, and recreation.
6. Residence for severely medically or physically handicapped persons. A special residence intended to stabilize medical problems so that residents may move to a more normative residence.
7. Intensive behavior shaping. A special residence for children or adults who have self destructive or other destructive behaviors, designed to replace these behaviors with appropriate positive living skills so that the person may move to a normative environment.
8. Structured correctional residence. A special residence for 1-5 juveniles or adults which provides pre-trial holding facility or residential program for adjudicated or paroled persons as an alternative to institutionalization (correctional or DMH). The focus of this program is on learning behaviors necessary for living in less structured environments.

D. Institutional services

1. State school/community preparation. Services provided include the development of skills prerequisite to independent living in the community.
2. State school/skills development. Services provided include training in self-care and activities of daily living necessary for preparation for community living.
3. State school/intensive behavior shaping. The provision of intensive training programs for children or adults who have self destructive or other destructive behaviors, designed to replace these behaviors with appropriate positive living skills so that the person may move to a normative environment.
4. State school/intensive medical services. Provision of intensive medical treatment for the stabilization of severe medical and physical disabilities.

5. State hospital/MR unit. Provision of training and supervision in a special mental retardation unit in a state hospital for the emotionally disturbed.
6. State hospital/unit for emotionally disturbed mentally retarded individuals. Placement in a specialized unit for the provision of intensive psychiatric treatment to ameliorate emotional disorders accompanying the resident's primary diagnosis of mental retardation.
7. Nursing home. Placement of mentally retarded persons in nursing homes, convalescent homes, and other facilities whose primary purpose is the care of persons with chronic illnesses.

II. Rehabilitative/Habilitative Services

These are services which are developmental in nature, designed to teach mentally retarded persons vocational, academic, or basic living skills. Excepting certain types of early intervention services, rehabilitative/habilitative services are rendered outside the clients' homes during normal working or school hours.

A. Vocational

1. On the job training/apprenticeship. Provision of highly supervised training from a vocational workshop setting. Also, the provision of training in work skills while the client works as an assistant/helper to a skilled employee.
2. Integrated industrial work station. The provision of supervised vocational training within regular industry. Clients are placed among regular employees to perform competitive jobs under the supervision of a person skilled in vocational training.
3. Non-integrated industrial work station. The provision of vocational training in an area of a factory floor or within an industrial park. Training involves acquisition of skills or performance of activities pertinent to competitive work within that industry - or similar jobs in other locations - or in a support function to the overall production by the industry.
4. Community sheltered workshop/industrial support. The provision of training in vocational and work adjustment skills in a specialized facility in the community. The principal activities of the workshop are assembly and piecework tasks the workshop acquires by contract

ing with industry. In order for a service to meet this definition, more than 50% of clients' work time must be spent on these industrial support activities.

5. Institutional sheltered workshop. The provision of training in vocational and work adjustment skills in a facility on the grounds of an institution operated by the Department. Workshops of this type are limited to those in which the clients engage in industrial support types of work, such as assembly, piecework, and other types of work generally contracted out by competitive industry.
6. Community sheltered workshop/production and marketing. The principle activity (at least 50% of the client's work time) of this type of workshop is the production of an item or items which the owners of the enterprise have determined to be in demand from consumers, and the marketing of that product. One example of this type of workshop would be the construction of industrial lift palets which are sold to general industry. Another example would be the operation of a bakery or other small business solely by mentally retarded workers under the supervision of non-retarded proprietors.
7. Institutional sheltered workshop/production and marketing. These services are the same as those delivered in a community setting, except the production site is located on the grounds of an institution operated by the Department.
8. Sheltered workshop/prevocational training. Services provided in this type of workshop are primarily training in work adjustment through noncompetitive activities. The work performed by the clients include woodworking, rug weaving, ceramics, and similar types of artistic endeavors. Under most circumstances the items made are sold by the workshop, with a portion of profit from sales going to the clients.
9. Institutional sheltered workshop/prevocational training. Activities performed here are like those of community based facilities, except they are carried out on institutional grounds.
10. Day activity/industrial support. The programs provide training in basic work adjustment and vocational skills in a noncompetitive environment through simple assembly and piecework secured by contract with private industry.

11. Institutional day activity/industrial support. These programs provide the same services as community-based programs except the site of the program is on institutional grounds.
12. Day activity/production and marketing. These services include the production and marketing of an item for consumption by industry or the general public in a noncompetitive environment in a specialized facility in the community.
13. Institutional day activity/production and marketing. These services are the same as those provided in the community, only the work is performed on institution grounds.
14. Day activity/prevocational training. These services include training in work adjustment and basic vocational skills through the manufacture of artistic products such as woven goods, woodcraft, ceramics, etc.
15. Institutional day activity/prevocational training. These services are the same as those provided by this type of day activity in the community except that the work is performed on the grounds of an institution.
16. Employment training. These services are those which teach mentally retarded adults the skills necessary to secure a job for which they have been trained and qualified. Activities include learning how to fill out job applications, participate in an interview, how to appear when applying for a job, etc.
17. Employment placement. These services are those which assist retarded adults with job procurement and job upgrading. Activities include the provision of assistance to employers and supervisors, consultation with unions, and support to the client to assure his/her success on the job.

3. Developmental Programs

1. Early intervention/in-home. The administration of infant stimulation programs by DMH - supported teachers in the clients' homes, for parent and infant training.
2. Early intervention/out-of-home. The administration of infant stimulation programs by DMH-supported teachers in an environment outside the clients' homes for parent and infant training.

3. After school programs. Provision of structured day training programs to school age children in addition to programs in which they participate that are provided by the public schools.
4. Adult education. Provision of educational programs for adults beyond school age in basic academic and technical subjects.

III. Ancillary and Supportive

These services include all those which a client may need (aside from residential and rehabilitative/habilitative services) in order to live productively. Services may be rendered to client, their families, providers of service, or the general public, but their principal focus is to enable mentally retarded persons to carry on normative lifestyles..

A. Case Management

1. Case-finding/outreach. These services include all activities involved in locating, identifying, and contacting mentally retarded persons or their families who may be in need of mental retardation services.
2. Intake. Intake services constitute any services rendered at the time a potential client applies for service. Initial contact, eligibility determination, application for service, initial interviews, development of service plans and objectives, and any other services provided prerequisite to being accepted for participation in a program may be considered intake services.
3. Family casework. Family casework services are those delivered to the families of mentally retarded persons. With respect to children, these services may be delivered in conjunction with individual casework services provided to the children. With adults, the casework services may only be directed at the family with the adult client receiving separate services. Family casework services may include counselling, follow-along, and supportive services to families.
4. Guidance and counselling. These services include general case management activities provided to ensure that there is continuity among the direct services client receives, that services are appropriate to

the client's needs, and that the client is acquiring necessary skills at an appropriate rate. Staff performing these services may act as advisors to clients as well as intercede on behalf of clients in solving problems with providers, in getting from place to place, and in overall adjustment to normative living.

5. Support and consultation to public schools. These services include liaison activities directed toward assuring continuity and consistency of training activities between the DMH services a client receives and his or her public education program. Staff provide technical assistance to teachers in developing techniques which have proven to be effective in accelerating the client's growth, communicating techniques developed in the schools to other staff working with the client's individual service plan and where responsibility lies in each aspect of the plan.

B. Therapeutic and Medical Services

1. General health services. These services include all services directed toward maintaining a client's state of good physical health. These services may be delivered as part of an organized general health plan (e.g. through a contract with DMH) or independently (e.g. the client is a member of a health maintenance organization or a member of a private physician's practice).
2. Special medical services. These services include any provided by a medical specialist, to correct or ameliorate a physical disability or disorder. Examples are services provided by orthopedists, ophthalmologists, orthodontists, physical and occupational therapists, etc.
3. Screening and diagnosis. These services include social psychological, and/or medical evaluations to determine the nature and extent of an individual's disability. Screening and diagnosis may also include more informal procedures designed to determine the appropriateness of a particular program for a client.
4. Speech and hearing therapies. Services provided by speech therapists and/or audiologists to correct or ameliorate hearing losses and/or speech and language difficulties.
5. Mental health services. Services provided by mental health practitioners to alleviate emotional or social

adjustment problems, emotional disturbance, or alcohol or drug dependencies.

6. Preventive health services. Medical and health-related services provided during the prenatal or perinatal period of growth to prevent the occurrence of mental retardation or to prevent the occurrence of circumstances which may result in the birth of a mentally retarded child. Prevention services may also be used to retard or arrest progressively deteriorating disorders, such as result from phenylketonuria and other inborn errors of metabolism, hydrocephalus, etc.
7. Mobility training. Services provided to assist a client to walk, walk with a prosthesis, move about in a wheelchair, or otherwise independently move from place to place.
8. Provision of prosthetic devices. The provision of artificial limbs or other body parts to ameliorate disabilities caused by missing limbs, or to improve the appearance of an individual through the provision of an artificial limb.
9. Visiting nurse services. Services provided by public health nurses or similar professionals or paraprofessionals in the clients' home, including developing nutritional programs, personal hygiene, and sanitary housekeeping practices.

C. Supportive services and administration

1. Information and referral. These services include the dissemination of information to clients and their families and the general public about services available to them. Information and referral consists not only of telling someone of the existence of a service but describing what use they could make of the service where it is located and/or rendered, and how to make contact. In some cases, information and referral might include actually contacting another agency on behalf of the individual and otherwise assisting in whatever capacity is necessary to ensure that the individual receives the services he/she needs and is entitled to.
2. Parent training. Parent training includes the provision of any assistance and/or instructions to parents of mentally retarded persons which will enable them to respond to the needs of their mentally retarded family member. Training might be provided to develop the

parents' skills in modifying problem behavior, to help them organize their home and family routines in ways that promotes maximum participation by the retarded child, or to develop the parents' ability to teach their child the necessary self-help and daily living skills.

3. Sex education. Sex education includes the provision of direct instruction to mentally retarded persons in sexual development, human sexuality, appropriate social and "dating" behavior, and in the various types and methods of birth control and their use.
4. Recreation. Recreation services include not only organized leisure time activities for groups of mentally retarded people, but also training in how to use recreational resources in the community and assistance in securing memberships in local clubs and/or recreation associations.
5. Transportation. The organization of any mode of conveyance from residence to the site of training programs and/or leisure-time activities for mentally retarded persons may be construed as transportation services. Examples include assisting persons to learn how to use public transportation, organizing car pools, and the direct provision of transportation with specially equipped vans, buses, etc.
6. Public education. Public education services include all instructional and/or public relations activities designed to increase public knowledge about mental retardation, services available to mentally retarded persons and their families, mentally retarded persons as citizens in the community, etc. Public education may be provided through media presentation, printed publications, speakers bureaus, tours through program facilities, interviews with clients, etc.
7. Staff training and development. Staff training and development activities include the provision of direct instruction to staff to improve or broaden their professional or technical skills, participation in degree or non-degree programs offered at colleges and universities, and/or attendance at workshops, seminars, and conferences conducted in areas pertinent to their job functions.
8. Court liaison. Court liaison services include the provision of technical assistance or supportive information to the courts about mental retardation and

specific mentally retarded persons to help guarantee the protection and maintenance of their legal and civil rights.

9. Administrative services. Administrative services include all non-direct client-related activities necessary to manage and operate a system of services for mentally retarded persons. Administrative services include systems and program management and planning, bookkeeping and fiscal accounting, record-keeping and information organization and reporting.
10. Volunteer services. These services include the administration, supervision, and coordination of services performed by volunteers, such as citizen advocates, foster grandparents, service organizations, and other members of the general public who work with mentally retarded persons without charge.
11. Individual Service Plan Development. The performance or coordination of activities essential to the development of individual service plans. Activities include but need not be limited to securing needed diagnoses and evaluations, organizing teams to define program priorities and client objectives, writing the plans, and counselling clients and families regarding the content of the plan. Regular and periodic reassessment, updating, and/or revising individual service plans may also be considered activities in this type of service.

APPENDIX 2

DEFINITIONS¹

ambulatory - able to walk independently, without assistance

mobile nonambulatory - unable to walk independently or without assistance, but able to move from place to place with the use of devices such as walkers, crutches, wheel chairs, wheeled platforms and so forth.

nonambulatory - unable to walk independently, without assistance

¹CFR45249.13(h) - ICF/MR Regulations 1/74

APPENDIX 3

COMPOSITION OF REGIONAL TEAMS

1 psychologist
1 behaviorist
1 social worker
1 physical therapist
1 occupational therapist
1 speech therapist
1 nurse
2 program development specialists
1 secretary

motor development/prosthetic device development teams
add to above

1 finish carpenter
1 follow-up worker (motor therapist or o.t. or p.t.)

APPENDIX 4.

Functions of ICF/MR		Focus of Responsibility
Area Office	X	ADMIN.
Regional Office	X	CLIENT MGMT.
State Operated Facility	X	RECORDS - CENTRAL
Residential Program	X	RECORDS - ONGOING
Day Program	X	RES. LIV. SERVICES
Support Services	X	NURSING & HEALTH
ICF/MR	X	SAFETY & SANITATION
Generic Service	X	DIET. SERVICES
	X	PHARM. SERVICES
	X	RECREATION
	X	PROF. SERVICES P.T., O.T., S.T., PSYCH., SW
	X	DENTAL - MEDICAL
	X	TRNG. & HABIL. SERVICES
	X	LAUNDRY
		MAINTENANCE
	X	PRE-ADMIN. EVAL.
	X	RE-EVAL.

	Functions of ICF/MR	Responsibility
Area Office	X	ADMIN.
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ICF/MR	X	SAFETY & SANITATION
Generic Service	X	DIET. SERVICES
	X	PHARM. SERVICES
	X	RECREATION
	X	PROF. SERVICES P.T., O.T., S.T., PSYCH., SW
	X	DENTAL - MEDICAL
	X	TRNG. & HABIL. SERVICES
	X	LAUNDRY
	X	MAINTENANCE
	X	PRE-ADMIN. EVAL.
	X	RE-EVAL.

Functions of ICF/MR		Responsibility	Area Office	Regional Office	State Operated Facility	Residential Program	Day Program	Support Services	ICF/MR	Generic Service
	ADMIN.		X							
	CLIENT MGMT.		X							
	RECORDS - CENTRAL		X							
	RECORDS - ONGOING		X							
	RES. LIV. SERVICES					X				
	NURSING & HEALTH					X				
	SAFETY & SANITATION					X				
	DIET. SERVICES					X				
	PHARM. SERVICES									X
	RECREATION									X
	PROF. SERVICES P.T., O.T., S.T., PSYCH., SW		X							
	DENTAL - MEDICAL									X
	TRNG. & HABIL. SERVICES					X	X			
	LAUNDRY					X				
	MAINTENANCE					X				
	PRE-ADMIN. EVAL.		X							
	RE-EVAL.		X							

Functions of ICF/MR		Locus of responsibility
Area Office		ADMIN.
Regional Office		CLIENT MGMT.
State Operated Facility		RECORDS - CENTRAL
Residential Program		RECORDS - ONGOING
Day Program		RES. LIV. SERVICES
Support Services		NURSING & HEALTH
ICF/MR	X	SAFETY & SANITATION
Generic Service	X	DIET. SERVICES
	X	PHARM. SERVICES
	X	RECREATION
	X	PROF. SERVICES P.T., O.T., S.T., PSYCH., SW
	X	DENTAL - MEDICAL
	X	TRNG. & HABIL. SERVICES
	X	LAUNDRY
	X	MAINTENANCE
	X	PRE-ADMIN. EVAL.

APPENDIX 5

BREAKDOWN OF INSTITUTIONAL COSTS

	<u>Indirect Costs</u>	<u>Operating Costs</u>	<u>Capital Costs (40 mil.)</u>	<u>Additional Capital Costs</u>	<u>TOTAL</u>
B	\$4,371,176	\$12,123,737	\$552,000	\$	\$17,046,913
M	4,422,273	13,488,117	598,000	503,056	19,011,446
F	6,388,699	19,233,581	828,000	312,064	26,762,344
H	1,982,266	4,895,563	92,000		6,969,829
W	4,742,969	15,847,313	1,288,000	603,520	22,481,802
D	4,753,063	16,060,031	782,000	332,672	21,927,766
	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
AL	\$26,660,446	\$81,648,342	\$4,140,000	\$1,751,312	\$114,200,100

APPENDIX 6

Ratios Used for Reallocation of Institutional Staff.

RATIOS FOR GROUPS 9, 10. & 11

	Group 9	Group 10	Group 11
RN	1:130	--	11:173
LPN	1:26	1:134	1:74
Psych.	1:104	1:136	1:173
SW MSW Aide	1:104 1:35	1:34 1:136	1:173 1:52
ST Aide	1:104 1:30	-- --	1:173 1:52
OT Aide	1:104 1:7	1:272 1:68	1:130 1:26
PT Aide	1:260 --	1:272 --	-- --
Rec. Therapist	1:52	1:68	1:52
Direct Care			
1:8	137	1:8	1:13
1:8	137	1:8	1:13
1:16	68	1:17	1:13
	1:1.36	1:1.68	1:2.5

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